Hamilton.

SUBMISSION

TO THE

MEDICAL SERVICES INSURANCE ENQUIRY

Presented by

WINDSOR MEDICAL SERVICES, INC.

1427 Ouellette Avenue

WINDSOR - ONTARIO

December, 1963

WINDSOR MEDICAL SERVICES, INC.

1427 OUELLETTE AVENUE

WINDSOR, ONTARIO

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REPRESENTED BY

Dr. E. Durocher

Dr. E. A. Roemmele

Dr. J. R. Barber

Mr. W. V. Walpole

WMS - in favor of well baby care.

W.M.S. - participating MDs - extra bills when annual income over 7M. single. 10M. married.

Proration - 90% OMA rates. - pay direct to M.D.

Participation - 98% M.D.s.

W.M.S. - excludes psychiatry. Feel there must be a limitation on payment of private psychiatric fees. Includes well baby care - 0-1 yrs.

SUMMARY

1. Our Brief deals with Bill 163 as it is presently written.

2. We endorse the principles of Bill 163 in that coverage be
   (a) Voluntary
   (b) Universally available, and
   (c) Offered through multiple carriers.

3. The development, progress and enrollment of Windsor Medical Services, Inc. are outlined and we have indicated how much W.M.S. has done to extend coverage to the so-called uninsurable and to the medically high cost older person.

4. The submission deals mainly with suggestions for revision of certain sections of this Act.

5. Suggestions are included to add some new sections and delete others.

6. The makeup, duties and voting procedures of Medical Carriers Incorporated are given.

7. Included is a suggestion that a Co-ordinating Directorate be established and the Brief outlines the makeup and duties of this body.

8. We have outlined a method by which the marginal income group may be identified.

RECOMMENDATIONS

1. That this Act indicate that it is the right of the individual to choose his physician and the right of the physician to select his patients.

2. That a comprehensive medical services insurance contract, indicated in this Act as Schedule A, be the only compulsory contract included in this Act and that, therefore, Schedule B be deleted.

3. That pooling be mandatory with provision for opting out.

4. That Medical Carriers Incorporated be a technical body only.

5. That a Co-ordinating Directorate be set up in this Act to formulate and administer policy.

6. That tax dollars be used to pay the premiums, in whole or in part, according to need, for those persons in the indigent group and the marginal income group.

7. That coverage for those persons outlined in Schedule C be provided through the Medical Welfare Plan.

8. That coverage for the marginal income group be provided through multiple carriers.

continued ...

9. That persons covered under recommendations 6 and 7 be provided with the benefits outlined in Schedule A on a first dollar coverage basis.

10. That the monthly subsidy for the marginal income group be $3.00 single, $6.00 married and $7.50 family but in no case shall the subsidy be greater than the premium.

11. That a carrier be required to accept applications for enrollment from those persons only who are without coverage at the initial enrollment period or any subsequent open enrollment period.

12. That any person, terminating a medical services insurance contract for any reason except fraud or failure to pay the premium required, be granted a standard medical services insurance contract by the same carrier.

BRIEF TO THE MEDICAL SERVICES INSURANCE ENQUIRY RE BILL 163

1. As one of the oldest physician-sponsored, non-profit, prepaid, medical care plans in Canada, Windsor Medical Services, Inc. (W.M.S.) welcomes the opportunity to present its Brief to the Medical Services Insurance Enquiry re Bill 163, An Act Respecting Medical Services Insurance.

PHILOSOPHY OF PREPAID PHYSICIANS' SERVICES

2. W.M.S. has long felt it to be of ultimate importance that every person should have available to him a vehicle by which he could prepay the cost of his physicians' services. To this end we have provided leadership by offering to the public comprehensive coverage with medical, surgical and obstetrical benefits on a group, group conversion and a non-group basis.

NON-GROUP COVERAGE

3. In 1959 W.M.S. introduced its non-group agreement which offered the same extensive benefits to individual subscribers as were provided to group subscribers. This coverage is provided without restriction as to age or state of health. This "off the street" type of enrollment has proven very popular with the self-employed and the elderly, both of whom previously had found it very difficult to obtain comprehensive individual policies.

[illegible] [redacted] may continue of [illegible] [illegible].

[redacted] of cost – may continue on the edge = loan rate.

MCI – [illegible]

ENROLLMENT TODAY

4. As at September 30, 1963 W.M.S. had the following enrollment.

Groups	177,405
Group Conversions	41,233
Non-Group	16,954
Total	235,592

5. W.M.S. has advocated that tax dollars could be used to defray the premium, in whole or in part, for those persons in needy circumstances. The mechanics required in the carrying out of this program are dealt with in another section.

6. Within the foregoing framework we advocate that it should be the basic right of the individual to choose his physician and it should be the right of the physician to select his patients.

7. Having stated our fundamental philosophies we now turn our attention to Bill 163, and we would like to deal first with Schedule B.

SCHEDULE B

8. Schedule B is a catastrophic type of insurance with first dollar coverage and, as such, is certainly preferable to any type of deductible or co-insurance plan. The experience of W.M.S., however, indicates that this type of coverage is undesirable and we offer the following reasons.

9. From 1945 through to 1959 W.M.S. offered a partial or limited type coverage at a cost of about one third of the premium for comprehensive

care. Maximum enrollment in this plan was reached in 1947 with 2,509 persons enrolled. By 1959 this enrollment had declined to 202 persons at which time the Board of Directors felt it was unwise to continue this plan any longer. Those 202 persons were allowed to continue their protection by transferring to our more comprehensive plan.

10. Other reasons for eliminating Schedule B from Bill 163 are as follows:

(a) This type of program causes patients to put pressure on doctors to admit them to hospital for relatively minor conditions; this, in turn, puts pressure on hospital accommodation which, in most areas, is taxed to its limit.

(b) It discriminates against the general practitioner because it eliminates home and office care as a benefit.

(c) It creates poor public relations when the subscriber or his dependent gets coverage only if he is hospitalized and, in many cases, hospital accommodation will not be available.

(d) It can lead to relatively expensive cases being left without coverage. As examples, many patients with fractures do not necessarily require hospital admission or many with chronic conditions, such as diabetes, which require a good deal of medical supervision yet with no necessity to be hospitalized.

11. In consequence of the foregoing reasons, we suggest that all references to Schedule B in this Act be deleted.

BILL 163

SECTION 1 - Interpretation

12. Section 1 deals with the interpretation, and there are certain sub-sections in Section 1 which we feel require further elaboration or clarification. 1.(a) "Benefit". We feel the words "or on behalf of" should be added immediately following "means a payment made to".

13. 1.(a) will then read

> "benefit" means a payment made to <u>or on behalf of</u> a covered person for medical or surgical care or services or the performance of such care or services for a covered person under a medical services insurance contract;

14. This change will allow those carriers who presently pay directly to the doctor for services rendered to their subscribers or policy-holders to continue to do business in their usual manner.

15. We believe the following wording would lend more clarity to the definition of dependent than that presently used in the wording of this Act in Section 1.(d) (ii) and 1.(d) (iii) and that, therefore, these two sub-sections be combined to read:

16. 1.(d) (ii) a son or daughter, or step-son or step-daughter of the head of a family who is dependent for support on the head of the family and who is

(a) under the age of 19 years and unmarried, or

(b) 19 years of age or over, mentally or physically infirm, and dependent for support on the head of the family or upon the spouse of the head of the family before his 19th birthday but does not include the spouse or dependents of any such child.

17. Section 1.(e) interprets "guaranteed renewable" to mean the right conferred upon a covered person, in the absence of misrepresentation or non-payment of subscription, to continue a medical services insurance contract in force from the date of issue until the carrier is no longer licensed under this Act. It is our recommendation that the carrier should be provided some protection against misuse of services and would suggest that the words "or proven continued misuse of services" be inserted immediately following the word "subscription". We would also suggest that the word "standard" precede "medical services insurance contract" in this same sub-section.

18. Section 1.(e) will then read

"guaranteed renewable" means the right conferred upon a covered person, in the absence of misrepresentation or non-payment of subscription or proven continued misuse of services, to continue a standard medical services insurance contract in force from the date of issue until the carrier is no longer licensed under

this Act;

19. Section 1.(i) defines "medical services insurance" and makes provision for excluding coverage under this Act when such coverage is already provided under another insurance policy. We believe that the words "provided in conjunction with" should be deleted and replaced with the words "which may be included in a contract of accident",

20. Section 1.(i) will then read

> "medical services insurance" means a contract, agreement, scheme, fund or arrangement wnereby a resident is covered for medical or surgical care or services or the cost or a portion thereof when rendered to such resident and his dependents by or under the direction of a physician, but does not include the limited and incidental insurance against medical and surgical expenses <u>which may be included in a contract of accident</u>, motor vehicle liability, employer's liability, public liability or workmen's compensation insurance;

21. Section 1.(n) defines a "resident". We suggest that the following wording be used as being more specific.

22. Section 1.(n) will now read

> "Resident" means an individual who is legally entitled to remain in Canada, who makes his home and ordinarily resides in Ontario and <u>whose most recent period of residency has been ninety consecutive days but does not</u>

include a tourist, a transient or a visitor to Ontario.

SECTION 3

23. Section 3 makes provision for the Minister, in accordance with the regulations, to purchase or contribute to the purchase of medical services insurance contracts for the indigent and the marginal income group. We believe these provisions should be contained in this Act rather than provided under regulations. We suggest, therefore, that "regulations" be deleted and replaced with "Act" in the opening sentence and in 3.(b) the words "in the regulations" be deleted and replaced with "this Act".

24. Section 3 will then read

> The Minister may, in accordance with this Act,
>
> (a) purchase standard medical services insurance contracts for such classes of persons as are set forth in Schedule C and who are in needy circumstances; and
>
> (b) contribute to the purchase of standard medical services insurance contracts for such other classes of persons as are set forth in this Act and who are in needy circumstances.

SECTION 4

25. Section 4 of Bill 163, in its present form, leaves the door open for the practice of discrimination by a municipality, inasmuch as it allows some recipients of municipal assistance to be covered by a comprehensive type of program and others by one of lesser coverage.

We recommend that all persons who are recipients of public assistance be provided with a standard medical services insurance contract according to Schedule A.

26. Section 4 will then read,

A local municipality may, on behalf of residents residing therein,

(a) who receive municipal unemployment or other assistance, or

(b) who are referred to under section 54 of The Public Health Act,

purchase or contribute to the purchase of standard medical services insurance contracts for such residents.

SECTION 5

27. Section 5 deals with the condition precedent to writing medical services insurance. We recommend that this section read as follows:

5. No carrier shall sell or provide or offer to sell or provide any other form of medical services insurance unless,

(a) it offers for sale and issues,

(1) guaranteed renewable standard medical services insurance contracts to any and all persons who are not already covered by a contract of medical services insurance at the effective date of this Act,

(2) guaranteed renewable standard medical services

insurance contracts to those persons who are covered by a contract of medical services insurance issued by that carrier but who are obliged to discontinue by reason of age or who cease to be a member of the group for any reason except misrepresentation or fraud or failure to pay the premium required.

28. The foregoing provides free choice of carrier to all persons who are without coverage at the time this Act becomes effective. However, it is our firm belief that there is a moral responsibility on the part of the carrier who writes group medical services insurance contracts to continue to provide coverage to those persons whose group coverage terminates. If such persons desire standard medical services insurance contracts it is only fair to suggest that the issuance of such contracts be the responsibility of the original carrier. We do not suggest, however, that this be the only carrier from whom such persons could purchase standard medical services insurance contracts but we do suggest that it should not be mandatory on other carriers to accept these persons' applications.

29. Section 5.(b) requires that a carrier be a member in good standing of Medical Carriers Incorporated (M.C.I.). With the indulgence of the Committee we would propose to discuss the ramifications of M.C.I. at this time. We agree with the interpretation of M.C.I., as outlined in Section 1.(h). However, we recommend that the objects of M.C.I.

be spelled out in this Act and that they be as follows:

(1) To consider and set maximum premium rates for the standard medical services insurance contract.

(2) To set an initial open enrollment period and such enrollment procedures as seem advisable to M.C.I.

(3) To determine the qualifications for membership in M.C.I.

(4) To administer a pooling arrangement which shall be mandatory on all members, unless a carrier can demonstrate to M.C.I. that it has enrolled as large or larger proportion of the so-called "uninsurables", the high risk individuals and the aged than the average enrollment of such risks by all carriers. In either case, a carrier may apply for exemption from the pooling arrangement on an annual basis.

(5) To deal with such other matters as relate to the technical administration of the standard contract.

30. Perhaps we should clarify and elaborate on our reasons for suggesting the above aims and objects, which we will do in the same order as they are set out.

31. It is necessary to set a maximum premium to eliminate the possibility of any carrier establishing a rate for a standard medical services insurance contract at a level which would be unacceptable to the public and, therefore, it would not be carrying its fair share of all risks. A maximum premium is also necessary for the protection of the general public.

32. Carriers are familiar with open enrollment periods and are in a preferred position to determine the length of time allowed for an open enrollment period and the frequency of subsequent enrollments.

33. Since M.C.I., in our proposal, would be composed of carriers it would seem reasonable to suggest that they should set certain standards which each carrier would be required to meet in order to assure the public of proper coverage.

34. A pooling arrangement is a method devised by the carriers for the sharing of losses incurred through covering those persons whose medical costs are known to be high and those persons who are known to be potentially high cost.

35. It should be noted that we have made provision in object number (4) for a carrier to be exempted from the pooling arrangement.

W.M.S. COVERAGE FOR HIGH COST AGED GROUP

36. To illustrate how well W.M.S. is fulfilling its role as a carrier in covering the so-called "uninsurable", the high risk and the aged, we cite the following figures. Using the estimated population of Canada and the Provinces in 1962, as provided by the Dominion Bureau of Statistics, we note that Ontario had a total population of 6,342,000 and this figure breaks down as follows.

Ages	0 to 19	2,514,800
	20 to 64	3,309,100
	65 and over	518,100

This indicates a total of 3,827,200 were over age 20 and of this total 13.5% were over age 65.

37. Comparable figures for Windsor Medical Services as at September 30, 1963 were as follows.

Ages	0 to 19	95,989
	20 to 64	121,987
	65 and over	17,616

You will note that of the total number of persons, 20 and over, of which there are 139,603, 12.6% are over age 65. This clearly indicates our reason for suggesting that a carrier should be allowed to opt out of the pooling arrangement if it so desires, providing it is fulfilling certain standards.

38. Object number (5) allows M.C.I. to deal with any other technical problems arising in the administration of a standard medical services insurance contract.

39. It should be noted that the above objects are all of a technical nature and it is our recommendation that M.C.I. should be a technical organization only.

BOARD OF DIRECTORS - M.C.I.

40. This, then, leads us to the makeup of the Board of Directors of this Corporation. We recommend that the Directors be elected at the Annual Meeting to represent groups of common interest, as provided for in Section 113 of The Corporations' Act, which reads as follows:

"The Directors of a corporation may pass by-laws providing for,

a) the division of its members into groups, either territorially or on the basis of common interest,

b) the election of some or all of its directors,

i) by such groups on the basis of the number of members in each group or

ii) for the groups in a defined geographical area, by the delegates of such groups meeting together".

41. We would further define the makeup of this Board of Directors, as follows: two members from Carriers licensed under the Insurance Act, one from Co-operative Medical Services Federation of Ontario, one from Cumba Co-operative Health Services, one from Associated Medical Services, one from Physicians' Services Incorporated and one from Windsor Medical Services, Inc. We further recommend that each Director be a permanent resident of the Province of Ontario.

SECTION 8 - M.C.I.

42. Section 8, sub-section (2) indicates that the assessment by M.C.I. would be levied on each carrier in an equitable manner by the Board of Directors of the Corporation and confirmed by at least two-thirds votes cast by the members present in person or represented by proxy and entitled to vote at any Annual or General Meeting of the Members of the Corporation. We recommend that the expense involved in

operating M.C.I. be apportioned to each carrier on a flat rate basis, each carrier being charged the same amount of money.

43. The reasoning behind the foregoing recommendation is that M.C.I. will be doing exactly the same amount of work for each carrier, regardless of the volume of business done by any given carrier.

SECTION 8.(3) - Voting - Annual Meeting - M.C.I.

44. Section 8, sub-section (3) sets forth a voting procedure which we assume refers only to votes cast in acceptance or rejection of an assessment. We recommend that, at the Annual or a Special General Meeting of Members when voting on all or any matter, the number of votes cast by a member shall be in direct proportion to the number of persons covered by the member under contracts of medical services insurance in relation to the persons so covered by all members and the by-laws of the Corporation may provide the necessary regulations with respect thereto. Such contracts of medical services insurance, to be eligible for voting privileges, shall be equal to or greater in coverage than a medical in-hospital, surgical contract.

45. Section 8. (3) will then read

> At an Annual or Special General Meeting of Members, **when** voting on all or any matter, the number of votes cast by a member shall be in direct proportion to the number of persons covered by the member under contracts of medical services insurance in relation to the persons so

covered by all members and the by-laws of the Corporation may provide the Regulations with respect thereto. Such contracts of medical services insurance to be eligible for voting privileges shall be equal to or greater than a medical in-hospital, surgical contract.

46. To follow the foregoing approach to Medical Carriers Incorporated would obviate the necessity of having sub-sections (4), (5) and (6) of Section 8 and, therefore, we would recommend their deletion from this Act.

CO-ORDINATING DIRECTORATE

47. In view of our recommendations that M.C.I. be a technical corporation only, it follows that a policy-making body should be established. We recommend that such a committee be set forth in this Act and known as the Co-ordinating Directorate and that the makeup of this Committee be as follows: three representatives from the medical profession, appointed by the Ontario Medical Association; three representatives from the Carriers, appointed by the Board of Directors of M.C.I. and such appointments to be ratified by the Annual or Special General Meeting of the Members of M.C.I.; three appointed by Government to represent the consumer-government aspect, one of whom would represent Government and two to be named from citizens outside of Government. All representatives must be permanent residents of the Province of Ontario.

48. We would also recommend that the foregoing appointments be for a two year period and that the duties of this Directorate be as follows.

1. To keep the operation of this legislation under review.
2. To consider and deal with any problems as presented by M.C.I.
3. To consider and make recommendations to the Minister relating to all proposals with respect to regulations on medical insurance prior to Government action thereon.
4. To mediate problems between carriers and subscribers.
5. To mediate problems between carriers and physicians.
6. To act as a liaison committee for all interested parties.

SECTION 6

49. Section 6 expressly permits carriers to sell contracts providing greater benefits than those provided under this Act. We believe this section should also, therefore, permit carriers to sell contracts providing less benefits than those provided under this Act. We propose to divide this section into two parts to read as follows.

50. 6.(a) Nothing in this Act prevents a carrier from providing benefits under contracts of medical services insurance greater <u>or lesser</u> than those set forth in Schedule A.

6.(b) Nothing in this Act shall require a carrier to offer for sale any form of medical services insurance to

any resident who is enrolled at the effective date of this Act, or subsequently, in any form of medical services insurance provided by any other carrier.

51. We believe that a carrier should be allowed to sell various levels of coverage in the regular conduct of its day to day business. Our suggestion allows for levels of coverage both above and below Schedule A.

52. In Section 6, sub-section (b), we develop the same philosophy as shown in Section 5.(a) (2) and the basis of our reasoning is set out in paragraph 28.

SECTION 7 - Licensing of Carriers

53. Section 7.(1) provides that carriers obtain a license from the Minister. We suggest that the licensing of carriers be left in the hands of the Superintendent of Insurance and that the word "Minister" in this section be deleted and replaced with "Superintendent of Insurance".

54. Section 7.(1) will then read

Every carrier shall obtain from the <u>Superintendent of Insurance</u> and hold a license under this Act.

SECTION 12 - Subscriber Eligibility

55. Section 12 sets out the time limit allowed for a person who qualifies in order to obtain coverage without incurring the penalties as

described in Section 15. We agree with the time limit indicated but believe that the effective date of the contract should be given. We suggest, therefore, that the following words be added to the end of this section "to be effective on the first day of the month following date of application".

56. Section 12 will then read

> Where a person qualifies to apply for a standard medical services insurance contract only after the expiration of an open enrollment period, he is entitled to have the contract for which he applies issued to him if his application therefor is made and the subscription therefor paid within thirty-one days following the day upon which he so qualifies, <u>to be effective on the first day of the month following date of application</u>.

SECTION 15 - Late Applicants

57. Section 15 deals with late applicants. While we agree in principle that some penalty must be attached to the granting of coverage to those who procrastinate, it is our opinion that, to collect or accept subscription fees or premiums for which no benefit is available, is unethical. We would recommend that Section 15 be amended to read as follows:

> Subject to Section 18, where the application of a resident who is not a dependent, or the dependent

spouse of such a resident, for a standard medical services insurance contract is not made and the subscription paid therefor within the period prescribed by Section 11, 12 or 13, as the case may be, such resident or spouse may nevertheless apply for a standard medical services insurance contract at any time, and upon payment of one or more months subscription fees which shall apply to the first and subsequent coverage months, as the case may be, plus the late enrollment fee prescribed by Medical Carriers Incorporated, a contract shall be issued to such resident or spouse subject to the following limitations:

1. Three clear calendar months must elapse after the date of application before a standard medical services insurance contract becomes effective.
2. No benefit shall accrue for medical or surgical care or services rendered to a covered person during the seven months immediately following the effective date of the contract if such costs arise from pregnancy or resulting child-birth or miscarriage or conditions that result directly or indirectly therefrom.

SECTION 16 - Standard Contract - Terms and Rate Structure

58. Section 16 outlines the fixed terms of a standard medical services insurance contract. We recommend the words "or proven continued misuse of services" be inserted immediately following the word "misrepresentation" in Section 16, sub-section (a) which would then read as follows.

16.(a) not be terminated by the carrier except for misrepresentation or proven continued misuse of services or non-payment of the subscription; and

59. This is recommended for the same reason as shown for Section 1.(e) in paragraph 17.

60. Sub-section (b) of this same section outlines the formula to be used in applying the maximum monthly subscription rates. While it must be admitted that this is a relatively simple formula, we believe it to be somewhat unfair. In using x as the single rate and the family rate $2\frac{1}{2}$ times x it means that the two-person family would be paying exactly the same rate as a four-person family. Those persons falling in the maximum premium category are usually those in the upper age bracket, 65 and over. These persons seldom have dependents and, under the suggested schedule, they would be called upon to pay the maximum premium applicable to those persons with children. It, therefore, seems prudent to suggest the following

formula:

Single premium	x
Two-person family	2x
Family of three or more	$2\frac{1}{2}$x

SECTION 18 - Arbitrators

61. Section 18(2) deals with the selection of arbitrators when the Superintendent of Insurance does not consent to the adjustment of the maximum subscription rate. Although the selection of an arbitrator could be accomplished through the Canadian Health Insurance Association, for most if not all carriers licensed under the Insurance Act, no such parent body exists for "all other members". We, therefore, suggest that M.C.I. appoint one arbitrator as representing all carriers and that the Co-ordinating Directorate appoint the second with the third to be appointed as indicated at present in this Act.

62. Section 18 (2) will then read

> "If the Superintendent does not within thirty days of the date of application by Medical Carriers Incorporated consent to the adjustment of the maximum subscription rate, the matter shall be referred for decision to a board of three arbitrators, <u>one to be named by the Board of Directors of M.C.I., one to be named by the Co-ordinating Directorate and one to be named by a</u>

Judge of the Supreme Court upon the application of the other two arbitrators".

SECTION 20 - Double Coverage

63. Section 20 deals with double coverage. This entire section should be re-drafted to state that it shall be illegal for any person to accept a payment through a standard medical services insurance contract, where he is receiving benefits for the same service from any other contract of insurance.

SCHEDULE A

64. Schedule A of Bill 163 outlines the benefits and the exceptions. We would recommend that the description of benefits provided by a standard medical services insurance contract be described in the following manner. "Subject to the provisions of this Act the expense incurred by a covered person for necessary personal professional services of a physician wherever rendered unless excepted under this Act or under this Schedule".

65. Under exceptions we recommend that

1. Be deleted because we believe that annual or periodic health examinations are a necessary part of preventive medicine. If all citizens had a medical examination at regular intervals many diseases would be detected early enough to carry out proper medical treatment and, in many cases, a permanent cure effected.

2. Be combined with 4 to read:

Services that a covered person receives, which services he is entitled to receive without charge, including,

(i) services received when he is a patient in any type of institution or special hospital when such services are paid for by the said institution or special hospital;

(ii) services obtained without charge by law.

(iii) services required in respect of an accident or sickness covered by any Workmen's Compensation Law or similar legislation;

We believe that to combine exceptions 2 and 4 provides a definition which could apply to types of institutions which might evolve in the future but which do not exist today for the treatment of disease.

6. This exception be deleted as it will be controlled by the O.M.A. Fee Schedule.

7. This exception be changed to read "Expenses for travelling time or mileage". This change allows the general public to more readily understand the meaning of this exception.

10. Group inoculations. We feel that the balance of

the wording contained in this exception has been covered by 2 (iii).

11. This exception be changed to read "Refractions". This would exclude as a benefit, refractions when done alone, but would not exclude complete eye examinations. This coincides with the current practice of ophthalmology.

SCHEDULE C

66. Schedule C outlines seven Acts in the Province of Ontario covering certain classes of persons who, if they are in needy circumstances, are provided benefits for home and office care through the Ontario Medical Welfare Plan.

67. We would recommend that the Ontario Medical Welfare Plan remain in operation to cover these persons but that such a plan should not be compelled to be a carrier under the terms of Bill 163. In addition, we recommend that the Ontario Medical Welfare Plan be expanded to include all the benefits of Schedule A.

68. We further recommend for those persons covered under Schedule C, if they are in needy circumstances, that the cost of their care through the Ontario Medical Welfare Plan should be totally financed by Government out of tax dollars.

69. There is another group of citizens in the Province who need partial assistance in the financing of their medical services insurance

premiums which we will refer to as the marginal income group. Since no firm statistics are available it will be necessary for us to make certain assumptions and estimates based on the data available in order to project a figure representing these people.

70. Mr. Guy C. Clarkson, M.A., employed in the Department of Medical Economics of the Canadian Medical Association, compiled a report dated October 1962 and titled "The Cost and Ability to Pay for Medical Services Insurance in Canada and its Provinces". Mr. Clarkson has used data from the Dominion Bureau of Statistics and Taxation Statistics, Department of National Revenue, as a basis for many of his calculations.

71. On page 16 of Mr. Clarkson's report he has developed data on the non-taxable plus non-reporting members in the labour force of each Province in 1959. In Ontario the total of these two figures was 505,269. On the same page of his report, under Table 13, Mr. Clarkson has developed the ratio of total population to the labour force by provinces as at December 1959. The Province of Ontario's ratio is shown as 2.6 to 1. When we apply this ratio of 2.6 to 1 to the 505,269 persons indicated above who do not pay income tax we arrive at a total of 1,313,700 persons who might be considered in the indigent and marginal income categories.

72. On page 18, Table 15, Mr. Clarkson shows a figure of 340,000 persons in Ontario which the Ontario Hospital Services Commission calculated to be indicative of the total indigent group which is some 140,000

greater than those persons covered on the Ontario Medical Welfare Plan. If we deduct this 340,000 which are considered to be the totally indigent from our original figure of 1,313,700 we are left with a residue of 973,700.

73. Since no yardstick is presently available as a standard by which we could measure the marginal income group we would recommend that the marginal income group be those persons whose gross income was equal to or less than their total personal exemptions for income tax purposes.

74. On the basis of our calculations thus far one must assume that in our figure of 973,700 there are persons whose gross income exceeds their personal exemptions even though they are in a non-taxable category due to the application of exemptions other than personal exemptions for income tax purposes. Without any firm basis for our figure let us assume that persons in this category amount to 73,700 which, when deducted from 973,700, leaves us with 900,000 persons in the marginal income group. For these people we would propose a subsidy of $3.00 single, $6.00 married and $7.50 family.

75. Notwithstanding these proposed subsidies, the amount of subsidy should in no case exceed the total amount of the premium.